

STATE OF HAWAII  
HAWAII LABOR RELATIONS BOARD

In the Matter of

DIRECTOR, DEPARTMENT OF LABOR  
AND INDUSTRIAL RELATIONS,

Complainant,

v.

PERMASTEELISA CLADDING  
TECHNOLOGIES, INC.,

Respondent.

CASE NO. OSH 2007-20

DECISION NO. 24

FINDINGS OF FACT,  
CONCLUSIONS OF LAW, AND  
ORDER

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

On August 8, 2007, Complainant DIRECTOR, DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS (Director or Complainant), through the Hawaii Occupational Safety and Health Division (HIOSH), issued a Citation and Notification of Penalty (Citation) to Respondent PERMASTEELISA CLADDING TECHNOLOGIES, LTD. (PERMASTEELISA or Respondent). The Citation resulted from Inspection No. 310391743 conducted from March 14, 2007 to July 27, 2007, and alleged in Citation 1, Item 1, a "serious" violation of 29 CFR § 1926.501(b)(1) (employees working without adequate guardrail system or fall protection) and imposed a penalty of \$2,500.00; in Citation 1, Item 2a, a "serious" violation of 29 CFR § 1926.502(a)(2) (inadequate fall protection system) and imposed a penalty of \$2,500.00; in Citation 1, Item 2b, a "serious" violation of 29 CFR § 1926.502(b)(2) (inadequate mid-rails between top railing and walking surface); and alleged in Citation 2, Item 1, an "other" violation of 29 CFR § 1926.503(b)(1) (no written records of fall protection training). Respondent contested the Citation by letter dated and postmarked August 31, 2007.

The Hawaii Labor Relations Board (Board) held an initial conference by telephone on October 11, 2007, attended by Herbert B.K. Lau, Deputy Attorney General, for the Complainant, and Alan K. Paperny, General Counsel, for Respondent. The Board issued Order No. 267, Pretrial Order, on October 11, 2007, and setting forth the issues in this matter as follows:

- (1) Whether Citation 1, Item 1, issued against Respondent on August 8, 2007, should be vacated because Respondent did not violate 29 CFR 1926.501(b)(1);

- (2) Whether Citation 1, Item 2a issued against Respondent on August 8, 2007, should be vacated because Respondent did not violate 29 CFR 1926.502(a)(2);
- (3) Whether Citation 1, Item 2b, issued against Respondent on August 8, 2007, should be vacated because Respondent did not violate 29 CFR 1926.502(b)(2); and
- (4) Whether Citation 2, Item 1, issued against Respondent on August 8, 2007, should be vacated because Respondent can provide information that its employees did receive fall protection training.

An evidentiary hearing in this matter was held on February 12 -13, 2008. The parties filed written closing statements/post-hearing memoranda on April 25, 2008. Based on a thorough review of the entire record and the arguments presented by the parties, the Board makes the following findings of fact, conclusions of law, and order vacating the Director's Citation 1, Item 1, Citation 1, Item 2a, Citation 1, Item 2b, and Citation 2, Item 1 and their associated characterizations and penalties.

#### FINDINGS OF FACT

1. PERMASTEELISA was for all relevant times, a subcontractor working on the Moana Pacific Condominium project (Moana Pacific) at 1230 Kapiolani Boulevard in Honolulu, Hawaii. The Moana Pacific consists of two high rise towers, East and West; each tower is 47 stories tall with over 300 units in each tower. Respondent was subcontracted to design and install the curtain wall or external facade of the structures, consisting of the aluminum frame and glass on the exterior of the building. Respondent also installed the sliding glass doors and railings on each unit. Respondent employed about 37 workers at the site.
2. Hawaii Dredging Construction Company (Hawaiian Dredging) was for all relevant times the general contractor of the Moana Pacific project.
3. Frank Montayre, Jr. (Montayre) was for all relevant times a 52-year old working foreman with 32 years of experience as an ironworker. Montayre was a member of the union and employed by Respondent since 2005. He previously worked on two other projects for Respondent, the Koolani and Hokua projects, prior to working on the Moana Pacific. On March 14, 2007, Montayre fell to his death from the 46th floor of the Moana Pacific East Tower, specifically Unit 4602, at approximately 9:59 a.m. There were no witnesses to the incident.

4. On March 14, 2007, HIOSH received a report that an ironworker fell from the 46th floor of the Moana Pacific project. Within two hours of the fall, HIOSH safety compliance officer Charles Flippo (Flippo) arrived at the Moana Pacific and began his investigation into Montayre's death. Flippo met Respondent's project manager, Jose Lupian (Lupian), and inspected Unit 4602 with Lupian, a representative of the medical examiner's office and a representative of the Honolulu Police Department.
5. Unit 4602 is a two bedroom unit with a three glass panel with a sliding glass door in the center separating the living room from the lanai. The sliding glass door ran along a three-inch high track. The lanai is about 14 feet long and 33 inches wide. A metal railing ran along the edge of the lanai supported by three 43-inch high vertical posts. The space between the posts was about 38.6 inches.
6. Approximately three weeks prior to March 14, 2007, it was discovered that the glass panels for the lanais for Units 4602 and 4502 could not be inserted into the recently installed metal railings. As a result, the metal railings on the lanais were not complete as the laminated glass inserts had not been installed.
7. Respondent's and Hawaiian Dredging's workers discussed whether to put in a wooden two-by-four mid-rail until the glass arrived. They had decided to install a guardrail but the lumber which was to be used for the railing was removed from the Unit. They also considered that it would be difficult to install the mid-rail and that it might not withstand 200 pounds of weight. They decided to set up Units 4502 and 4602 as "controlled access zones" (CAZ) by putting the red tape on the glass door to warn workers from going out on the lanai. Hawaiian Dredging locked the units and maintained exclusive control of the key for each unit. Doug Tsuji (Tsuji) of Hawaiian Dredging had the keys to the locked doors and Tsuji was responsible for letting anyone in or out of the CAZ. The procedure was to call Hawaiian Dredging to gain access to the room. The sliding glass doors leading to the lanais were closed and a four-foot long red tape reading "DANGER DO NOT ENTER" in two-inch high capital letters was taped at eye-level on the sliding glass doors to warn workers entering onto the lanai. A worker needed permission from authorized personnel to go beyond

the red tape.<sup>1</sup> A yellow banner was loosely strung along the lanai railing that read, "CAUTION WET PAINT."

8. Respondent's workers used personal fall arrest systems on the project which provides a higher level of safety than a guardrail or safety net system. A claw anchor hole was drilled into the living room concrete floor of Unit 4602 about 53 inches from the sliding glass door track. The worker is able to insert a retractable anchor bolt in the hole which is attached to the worker's personal fall arrest system.
9. On March 14, 2007, Montayre and his partner Francis Horne (Horne) began work at 7:00 a.m. They caulked the expansion joint gaskets which ran along the vertical walls on either side of the lanai about five inches from the edges. It was their practice to have Montayre caulk the lower half of the vertical expansion joint, and Horne later followed to caulk the upper half. Montayre did not need fall protection for the caulking except in Units 4502 and 4602; Horne needed fall protection because the area he caulked was higher than the 43 inch glass panels. They worked on the 45th and 46th floors of the tower. Montayre was caulking the units on the 46th floor and Horne caulked the 45th floor.
10. At about 9:45 a.m., Montayre and Horne decided to take a break on the 47th floor, in Unit 4703. They drank sodas and ate cupcakes and talked for about 15 minutes, then went back to work. According to Horne, they looked down at the two rooms they were going to resume their work on. Horne went to retrieve his equipment and Montayre picked up his bucket of materials and tools from his work cart and left the area to go down to the 46th floor. Montayre left his fall protection equipment in the break room.
11. Horne noticed that Montayre did not take his fall protection gear with him but he did not say anything to him. Horne was a few seconds behind Montayre as he descended down the stairwell to go to the 45th floor and someone passed him on the way up yelling that someone had fallen. Horne ran to Unit 4502 and discovered it was locked. Horne ran back up to Unit 4602 to check on Montayre and found the door was open. Horne looked towards the lanai and

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<sup>1</sup>The workers had varying perceptions as to what the words on the tape meant. Jack Birdwell, Respondent's Site Superintendent stated that "All union workers and subcontractors know not to open doors, where such tape is posted." Birdwell stated that nobody is supposed to go on the lanai if there is a sign "Danger! Do Not Enter" on the sliding door. Even he would have to call Hawaiian Dredging if he found the tape.

saw Montayre's bucket and some of his belongings on the lanai but did not see him and assumed that he fell.

12. Montayre's body was found on the ground 47 stories directly below Unit 4602. He was not wearing any personal fall arrest system. Montayre died of massive internal injuries received in the fall.
13. During Flippo's inspection of Unit 4602, the sliding glass door to the lanai was open. Flippo observed the red "Danger Do Not Enter" sign on the glass doors leading out to the lanai and concluded that it would have been clearly visible to Montayre. There was no guardrail or safety net along the lanai of Unit 4602. There also was yellow tape on the railing; one part of the tape was missing. Montayre's bucket, caulking gun, radio, and other items of equipment were observed on the lanai. Nothing was touched except that Montayre's radio was turned off. Flippo saw the anchor hole on the floor of Unit 4602 and no anchor bolt was found in the anchor hole.
14. Flippo went to the break area on the 47th floor where Montayre had taken a break immediately prior to his fall. At the break area, Flippo observed and inspected Montayre's personal fall arrest equipment on Montayre's work cart, consisting of his harness, rope and lanyard, which was undamaged and in good working order.
15. Based on his investigation, the Police Report and the Medical Examiner's Report, Flippo believed that Montayre was about to start work and something caused him to lose his balance and he fell through the railing to the ground, striking his head on the railing of the floor below.
16. Flippo believed Montayre and Horne may not have been aware that the two rooms did not have the glass installed. Flippo did not think the workers knew that this was a hazardous area and that the railings were unfinished. Horne mentioned that no one told him that the glass was missing and it wasn't necessary to take their gear with them.
17. In a follow-up interview Horne stated, "We were in there at least a week before the accident. The red tape was upon on both the glass doors and the rails. Frank was with me. We knew that the glass was not in the railing."
18. After the accident Hawaiian Dredging put the mid-rails on the balcony of Unit 4602 pursuant to Flippo's instruction. Lupian's employees installed the red tape to create a CAZ to make sure no one entered the lanai.

19. Montayre was trained in the use of the personal fall arrest system which was supplied by Respondent. As part of his investigation, Flippo interviewed numerous employees of Respondent asking the employees about Montayre's safety habits and the significance of the "Danger Do Not Enter" sign on the sliding glass doors in Unit 4602. All of the employees stated that Montayre was a safe worker. Flippo found that Montayre, a foreman, always made sure that his crew worked safely, that they had their equipment on. According to Respondent's Site Superintendent Jack Birdwell (Birdwell), Montayre was one of the safest workers and he never saw him violating any safety rules. Lupian confirmed that Montayre did not engage in unsafe practice and did not fail to use his fall protection equipment.
20. Flippo found that there was no reason why Montayre could not have used his personal fall arrest equipment in conjunction with the anchor hole in Unit 4602 so as to tie himself off while working on Unit 4602's lanai.
21. HIOSH requested fall protection training records for Montayre from Respondent but none were produced. Respondent and Hawaiian Dredging had site specific safety plans. Lupian testified that the foremen have additional responsibility for their safety and the safety of their employees working around them. Flippo requested inspection records for the month leading to the date of the accident but none were provided by the Respondent.
22. Hawaiian Dredging provided new employee orientation at every job site and was site-specific, including fall protection training. All of Respondent's workers received an orientation on Hawaiian Dredging's safety program prior to working on the job site. Although the Hawaiian Dredging employee orientation document does not reflect the specific safety subjects covered during orientation, Lupian testified that the orientation covered general topics such as the requirement to tie-off whenever a worker is more than six (6) feet above a lower level, and the three types of fall protection.
23. Hawaiian Dredging had weekly safety site meetings that all workers were required to attend. Workers used a sign-in sheet for each meeting. Birdwell testified that all of the Respondent's workers attended the meetings. Various topics were discussed. For example, during one of the meetings Hawaiian Dredging made it known that the lanai railings on other units were not installed and that fall protection was required beyond the sliding glass door. In such instances, Hawaiian Dredging required signage to be posted requiring workers to wear fall protection.
24. Respondent also provided its own orientation for its new hires at the site. Robert Yogi, Respondent's Safety Officer, was in charge of new employee

orientation at the Moana Pacific worksite. Respondent conducted weekly safety meetings where workers were informed that areas had been made controlled access zones and were instructed to be sure to wear and properly anchor their personal fall protection equipment when working in these areas. Respondent also held informal safety or toolbox meetings for its own workers on an almost daily basis in the mornings.

25. Birdwell performed daily walk-arounds for the purpose of keeping track of the workers, making sure they were doing their assigned tasks and job scheduling. He had the authority to discipline the workers but he did not have a ticket book.
26. Two to three months into his investigation, Flippo went on a medical leave and Clayton Chun (Chun), another Level IV inspector was assigned to the investigation. Flippo had not interviewed Tsuji or other Hawaiian Dredging personnel during his investigation.
27. Although Chun proposed the specific citations for Respondent, Flippo's investigation provided the basis for the citations. After resuming the investigation, Chun conducted one site visit and submitted ten written questions to Horne.
28. Flippo stated in his Pertinent Facts as follows:
  5. The victim was provided with fall protection equipment, training and all needed assistance to safely conduct this task.
  6. Evidence indicates that the victim did not retrieve his fall protection equipment to utilize in this instance.
  7. The area was clearly marked as a Danger zone, therefore preventing unauthorized personnel from entering it.
  8. The victim was diabetic and had been known to do insulin injections while working.
  9. The victim had just ingested a diet soda and cupcakes, containing high sugar content, that may have contributed to his accident.
29. In his Causal Analysis, Flippo indicated that the direct cause of the accident was that Montayre knew about hazard and failed to comply with the job site's safety procedures established by Respondent and Hawaiian Dredging and

applicable fall protection requirements. Flippo cited as an indirect cause that Montayre may not have been fully briefed by Respondent or Hawaiian Dredging before entering into the hazardous zone. If the door had been locked and the safety officer notified to open the door, the officer would not have permitted Montayre to enter the room without his fall protection. Flippo cited as contributing causes that the safety officers from either company were not on site. In addition, conducting a hazard analysis and communicating the findings to affected workers would serve to promote better communication and ensure a safer work environment.

30. On August 8, 2007, HIOSH issued a Citation to Respondent following Inspection No. 310391743.
31. Citation 1, Item 1, was a "serious" violation of 29 CFR § 1926.501(b)(1) and a penalty of \$2,500.00 which states as follows:

An employee was working on the 33" wide x 14' long balcony floor that had an inadequate guardrail system and was also not using his personal fall arrest system. The balcony had only a top railing measuring 43" high that was also supported with three separate metal posts 38.6" apart.

Three of the four sections were missing their laminated glass panels for the mid-railings. This employee was supposed to be caulking the rubber seal in between the expansion joint on the left side adjacent 8' high wall from the top railing down to the balcony's floor. Based on the information from this investigation and employee interviews this employee accidentally appeared to have fallen through the balcony's unguarded mid-railing opening on the left corner side and fell 378' down to the ground and died.

29 CFR 1926.501(b)(1) states: "Unprotected sides and edges. Each employee on a walking/working surface (horizontal and vertical surface) with an unprotected side or edge which is 6 feet (1.8m) or more above a lower level shall be protected from falling by the use of guardrails systems, safety net systems, or personal fall arrest systems."

- Citation 1, Item 2a, was a "serious" violation of 29 CFR § 1926.502(a)(2) and a penalty of \$2,500.00 which states as follows:

The employer did not adequately provide and install fall protection systems required by this subpart for their employee,



and did not comply with all other pertinent requirements of this subpart before their employee began the work that necessitated the fall protection. An employee was working on the 33" wide x 14' long balcony floor with only a top railing measuring 43" high. The top railing was also supported with three separate metal posts 38.6" apart.

Three of the four sections were missing their laminated glass panels for the mid-railings. This employee was supposed to be caulking the rubber seal in between the expansion joint on the left side adjacent 8' high wall from the top railing down to the balcony's floor. Based on the information from this investigation and employee interviews this employee accidentally appeared to have fallen through the balcony's unguarded mid railing opening on the left corner side and fell 378' down to the ground and died.

29 CFR 1926.502(a)(2) states: "Employers shall provide and install all fall protection systems required by this subpart for an employee, and shall comply with all other pertinent requirements of this subpart before that employee begins the work that necessitates the fall protection."

Citation 1, Item 2b, was a "serious" violation of 29 CFR § 1926.502(b)(2) which states as follows:

An employee was working on the 33" wide x 14' long balcony floor with only a top railing measuring 43" high. The top railing was also supported with three separate metal posts 38.6" apart. Three of the four sections were missing their laminated glass panels for the mid-railings. This employee was supposed to be caulking the rubber seal in between the expansion joint on the left side adjacent 8' high wall from the top railing down to the balcony's floor.

Based on the information from this investigation and employee interviews this employee accidentally appeared to have fallen through the balcony's unguarded mid-railing opening on the left corner side and fell 378' down to the ground and died.

29 CFR 1926.502(b)(2) states: "Mid-rails, screens, mesh, intermediate vertical members, or equivalent structural members shall be installed between the top edge of the guardrail system

and the walking/working surface when there is no wall or parapet wall at least 21 (53 cm) high.

Citation 2, Item 1, was an "other" violation of 29 CFR § 1926.503(b)(1) which states as follows:

The employer was unable to produce written records of their employees having received fall protection training before exposing them to fall hazards at this job site.

29 CFR 1926.503(b)(1) states "The employer shall verify compliance with paragraph (a) of this section by preparing a written certification record. The written certification record shall contain the name or other identity of the employee trained, the date(s) of the training, and the signature of the person who conducted the training or the signature of the employer. If the employer relies on training conducted by another employer or completed prior to the effective date of this section, the certification record shall indicate the date the employer determined the prior training was adequate rather than the date of actual training."

32. Lupian stated that guardrails and safety nets do not provide the same level of safety that a fall arrest system does. Lupian and Flippo tested Montayre's anchorclaw in the hole and found that it worked properly. Flippo told Lupian, short of having police officers behind every employee enforcing our safety program, there is not much more Respondent could have done.
33. With respect to Citation 1, Item 1, alleging a violation of 29 CFR § 1926.501(b)(1), after reviewing the record, the Board finds that the Respondent utilized a personal fall arrest system to protect its workers against fall hazards on the high rise Moana Pacific project. On March 14, 2007, Montayre, a veteran iron worker and working foreman, fell to his death while working on the 46th floor. The lanai of the unit Montayre was working on had three of four glass panels missing from the mid-railing leaving the balcony's side unguarded. An anchor hole had been drilled into the floor of the unit to insert the anchor claw for the fall protection equipment and upon examination by the HIOSH compliance officer, Montayre's equipment was fully functional. Tragically, Montayre was not wearing his personal fall protection equipment provided by Respondent when he fell. The Board accepts Flippo's opinion, that Respondent provided protection for Montayre from fall hazards by providing him a functional personal fall arrest system and thereby complied with 29 CFR § 1926.501. Chun testified that under 29 CFR 1926.502(a)(2) which states that

the employer shall provide and install all fall protection systems required by this subpart for the employee, it was his opinion that someone from the employer was required to insert Montayre's anchor into the hole for him. Lupian testified that he would install his own anchor because he didn't want to trust someone else with his life. Although the citing compliance officer testified that he expected Respondent to insert the anchor in the hole in order to comply with the HIOSH standards, the testimony of witnesses indicated that each worker installs his own anchor to engage his fall protection equipment.

34. Citation 1, Item 2a, alleging violation of 29 CFR § 1926.502(a)(2) and Citation 1, Item 2b, alleging violation of 29 CFR 1926.502(b)(2) concern the specifications to which a guardrail system must comply.
35. As to the alleged violation of 29 CFR 1925.502(b)(2), Flippo agreed that the section refers to a guardrail system and Respondent did not have a guardrail system. According to Flippo, Hawaiian Dredging is ultimately responsible for the site and Respondent did have a fall protection system in place. Flippo agreed that if the employer had one of the fall protection systems in place, it did not need another.
36. Chun acknowledged that although Respondent was cited for not having a guardrail system in place, no such system was required as Respondent utilized a personal fall arrest system. Chun acknowledged that 1) Respondent has the option of utilizing a personal fall arrest system on the Moana Pacific; 2) Respondent provided the personal fall protection equipment to Montayre; (3) Chun accepted Flippo's conclusions that it was adequate and usable; and (4) there is no OSHA regulation that would require Respondent to utilize a guardrail system.
37. Flippo indicated in his report that Hawaiian Dredging should have taken the responsibility and ensured a mid-rail was installed or kept the door closed. Flippo also stated that if Hawaiian Dredging personnel observed the hazard upon inspection and did not take the needed actions to correct it before ensuring workers would enter this area, it would constitute a failure in the company's safety program to enforce fall protection requirements. Flippo acknowledged that he needed to talk to some Hawaiian Dredging people but did not do so. In addition, although Chun thought that Hawaiian Dredging had overall responsibility for site safety for the project, he did not interview Hawaiian Dredging personnel.
38. With respect to 29 CFR § 1926.502(a)(2) and (b)(2), the Board accepts Flippo's finding that Montayre's personal fall arrest system provided by Respondent was compliant with the requirements of the subpart. In addition, the Board accepts

Flippo's finding that Respondent was not required to install a guardrail system as its method of fall protection because it already had a fully compliant personal fall arrest system. Thus, a guardrail system was not required. Therefore, based on the record, the Board finds that the Director failed to prove that the standards, 29 CFR § 1926.502(a)(2) and 29 CFR 1926.502(b)(2) apply to these facts.

39. Flippo testified that the site was not a proper CAZ. According to 29 CFR 1926.502(g)(2)(1), "[t]he Controlled Access Zone shall be defined by a controlled line erected not less than 10 feet, or more than 15 feet from the working edge." Flippo testified that when the sliding door was opened, there should have been a red banner across the room, at least 10 feet away from the door. Flippo testified that it would have been better to lock the door; it was his understanding that Dredging kept the doors locked so no one could enter. Id. Respondent was not cited for having an improper CAZ. Id.
40. In Citation 2, Item 1, alleging a violation of 29 CFR § 1926.503(b)(1), Respondent was cited for the failure to provide certification of fall protection training. Respondent produced documentation of orientation training provided by Hawaiian Dredging which included fall protection. Montayre completed an acknowledgment form that he received orientation regarding Hawaiian Dredging's safety materials. Respondent conducted toolbox meetings almost on a daily basis. Hawaiian Dredging also had weekly safety meetings.
41. Chun acknowledged that Hawaiian Dredging's orientation program included its safety program but did not review it prior to issuing the Citation.
42. Based upon the record, the Board finds that Montayre's acknowledgment of completion of Hawaiian Dredging's orientation program does not include the signature of the person who conducted the training or the signature of the employer. As such, the acknowledgment does not constitute a written certification record which complies with 29 CFR § 1926.503(b)(1).
43. The Board also finds that the investigation conducted by HIOSH did not include any inquiry of the general contractor Hawaiian Dredging. The record indicates that Hawaiian Dredging, as the general contractor, had responsibility for the safety on the job site. According to Birdwell, Hawaiian Dredging had exclusive control over the keys to Units 4502 and 4602 and Tsuji from Hawaiian Dredging would have the keys to the door. There was also evidence in the record that there may have been other keys made for the other trades to complete their work. The Board finds the HIOSH investigation did not address issues regarding who opened the door to Unit 4602, when the door was opened, whether other trades were working in the Unit 4602 when Montayre fell, who

opened the sliding doors, etc. The answers to these questions may have resolved whether others were responsible for the hazardous conditions and whether the HIOSH standards were violated.

### CONCLUSIONS OF LAW

1. The Board has jurisdiction over this contested case pursuant to Hawaii Revised Statutes (HRS) §§ 396-3 and 396-11.
2. Respondent is an employer within the meaning of HRS § 396-3, which provides in relevant part:  
“Employer” means:  

\* \* \*

(5) Every person having direction, management, control, or custody of any employment, place of employment, or any employee.
3. To establish a violation of a standard, the Director must prove by a preponderance of the evidence<sup>2</sup> that: (1) the cited standard applies, (2) there was a failure to comply with the cited standard, (3) an employee had access to the violative condition, and (4) the employer knew or could have known of the condition with the exercise of reasonable diligence. Director v. Maryl Pacific Constructors, Inc., OSAB 2001-18 (6/13/02).
4. The Director must prove that the employer either knew, or with the exercise of reasonable diligence could have known, of the presence of the violative condition. Secretary of Labor v. Seibel Modern Manufacturing & Welding Corp., 15 OSHC 128, 1221 (1991). The knowledge may be either actual or constructive. Constructive knowledge has been found when the hazard is in plain view. Rothstein, Occupational Safety and Health Law, 2007 edition; §5:15, p. 184, citing Kokosing Construction Co., Inc., 17 OSHC (BNA) 1869 (1996).
5. 29 CFR § 1926.501(b)(1) provides in relevant part:  
  
Unprotected sides and edges. Each employee on a walking/working surface (horizontal and vertical surface) with an unprotected side or edge which is 6 feet (1.8 m) or more above

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<sup>2</sup>HRS § 91-10(5).

a lower level shall be protected from falling by the use guardrail systems, safety net systems, or personal fall arrest systems.

6. 29 CFR § 1926.501(b)(1) is incorporated in Title 12, Subtitle 8, Part 3, Chapter 121.2, of the Hawaii Administrative Rules (HAR), Department of Labor and Industrial Relations, Division of Occupational Safety and Health, Construction Standards, Fall Protection, by HAR § 12-121.2-1.
7. The standard 29 CFR § 1926.501(b)(1) applies to the present case. The worksite is a residential tower being constructed which is 47 stories with 300 units. Montayre was last seen leaving the break area on the 47th floor to perform caulking work on the exterior expansion joint on the lanai and the equipment he was carrying when he left the break area was found on the lanai of Unit 4602. The lanai had an unprotected edge because three of the four glass panels were missing from the aluminum railing the vertical distance between Unit 4602 and the ground is more than six feet. Thus, the general protection requirement of 29 CFR § 1956.501(b)(1) is applicable.
8. Based upon the record, the Board finds that Respondent complied with the standard. Respondent had a personal fall arrest system being utilized at the Moana Pacific project at the time to protect its employees from fall hazards and provided a working personal fall protection system to Montayre. As a working foreman with a reputation of being safety conscious for himself and his men, Respondent had no reason to expect that Montayre would proceed to work on the lanai without his fall protection equipment. HIOSH's expectation that the Respondent insert the anchor for its workers' fall protection is unreasonable. Based upon the record, the Board concludes that Respondent did not violate 29 CFR § 1926.501(b)(1).
9. 29 CFR § 1926.502(a)(2) provides as follows:

Employers shall provide and install all fall protection systems required by this subpart for an employee, and shall comply with all other pertinent requirements of this subpart before that employee begins the work that necessitates the fall protection.
10. The foregoing provision is a general requirement that fall protection systems must comply with the pertinent requirements of the subpart.
11. Based on Flippo's testimony that upon inspection Montayre's personal fall arrest system was compliant with the requirements for personal fall protection, the Board concludes that Respondent did not violate 29 CFR § 1926.502(a)(2).

12. 29 CFR § 1926.502(b)(2) provides as follows:

Mid-rails, screens, mesh, intermediate vertical members, or equivalent intermediate structural members shall be installed between the top edge of the guardrail system and the walking/working surface when there is no wall or parapet wall at least 21 inches (53 cm) high.

13. The foregoing provision specifies requirements with respect to guardrail systems.

14. Based on Flipppo's testimony that if there was a fall protection system in place, in this case, a personal fall protection system, Respondent did not need to have a guardrail in place, the Board finds that the Director failed to prove that the standard is applicable to these facts. Based upon the record, the Board concludes that Respondent did not violate 29 CFR § 1926.502(b)(2).

15. 29 CFR § 1926.503(b)(1) provides as follows:

The employer shall verify compliance with paragraph (a) of this section by preparing a written certification record. The written certification record shall contain the name or other identity of the employee trained, the date(s) of the training, and the signature of the person who conducted the training or the signature of the employer. If the employer relies on training conducted by another employer or completed prior to the effective date of this section, the certification record shall indicate the date the employer determined the prior training was adequate rather than the date of actual training.

16. Based on the record, the Board concludes that Respondent produced a record that Montayre attended an orientation program given by Hawaiian Dredging which included fall protection training but did not indicate the date the employer determined the prior training was adequate rather than the date of the actual training. The record also does not include the signature of the person who conducted the training or the signature of the employer. Based upon the record, the Board concludes that Respondent violated 29 CFR § 1926.503(b)(1). The Board further concludes that the "other" characterization of the violation is correct.

ORDER

For the above-discussed reasons, Board hereby vacates the Director's Citation 1, Item 1, Citation 1, Item 2a, and Citation 1, Item 2b, and their respective characterizations and penalties and affirms Citation 2, Item 1 and its characterization.

DATED: Honolulu, Hawaii, November 24, 2008.

HAWAII LABOR RELATIONS BOARD



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JAMES B. NICHOLSON, Chair



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EMORY J. SPRINGER, Member



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SARAH R. HIRAKAMI, Member

NOTICE TO EMPLOYER

You are required to post a copy of this Decision at or near where citations under the Hawaii Occupational Safety and Health Law are posted. Further, you are required to furnish a copy of this order to a duly recognized representative of the employees.

Copies sent to:

Herbert B.K. Lau, Deputy Attorney General  
Douglas M. Poulin